PT ID – num5
(Contingent on Site# ; Site #1: 10001-19999, Site #2: 20001-29999, Site #3: 30001-39999, Site #4: 40001-49999)

PT Initials – chr3 (AA – ZZZ)

Visit # - num 2 (01-99)

Visit Date – DT (01/01/2008 – SYSDATE)

RC ID – chr3

Site # - num2 (01-04)

Clinical Center Codes/Names:

01 Hospital of the University of Pennsylvania (HUP), Outpatient Pulmonary Clinic
02 HUP Transplant Clinic
03 Presbyterian Hospital Pulmonary Clinic
04 ABI

Data Entry CRF Version Log

Form Name	Form Code	Latest Version Number
Participant Eligibility	**ELIG**	V3.0.20090213
Concomitant Medications	**CMED**	V3.0.20090225
Enrollment Visit Patient Information	**BASEINFO**	V3.0.20080320
Follow-up Patient Information	**FOLLOWUP**	V3.0.20090320
Lab Results	**LAB**	V5.0.20100322
Vitamin D Test Results Log	**VITD**	V1.0.20100324
PFT Results	**PFT**	V1.0.20060427
Testing Checklist	**TEST**	V2.0.20090127
Participant Reinstatement	**REINST**	V1.0.20060427
Participant Withdrawal	**WITHDR**	V1.0.20060427
Specimen Collection and Transfer	**COLLTX**	V2.0.20080825

Participant Eligibility

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

1. Did the participant sign informed consent? ☐1 Yes ☐0 No N:(1,0)

   a. If yes, date consent signed _ _/_ _/_ DT _ _ (mm dd yyyy)

INCLUSION CRITERIA

All responses to questions 2-4 must be "YES" in order for the participant to be eligible. If shaded response is checked participant is ineligible.

2. Is participant at least 18 years of age? ☐1 Yes ☐0 No N:(1,0)
3. Does participant have a diagnosis of asthma and/or COPD, confirmed by a pulmonologist or allergist in keeping with the definitions of the protocol, **OR** are they a healthy subject without any significant pulmonary disease? ☐1 Yes ☐0 No N:(1,0)

   a. If the answer to question 3 is "**1-Yes**", please confirm this participant's diagnosis: N:(1-4)
   - ☐1 Asthma
   - ☐2 COPD
   - ☐3 Asthma and COPD
   - ☐4 Healthy subject, no significant pulmonary disease

4. Is participant able and willing to sign an informed consent? ☐1 Yes ☐0 No N:(1,0)

EXCLUSION CRITERIA

The answer to question 5 must be "YES" in order for the participant to be eligible. If shaded response is checked participant is ineligible.

5. Did the participant meet all inclusion criteria? ☐1 Yes ☐0 No N:(1,0)

DEFERRAL CRITERIA

Any participant meeting any of the following criteria in questions 6-7 will be deferred for enrollment, but will be reassessed for eligibility at subsequent visits.

6. Did the participant indicate that he/she would like to take additional time to consider participation in the registry? ☐1 Yes ☐0 No N:(1,0)
7. At the time of initial assessment for registry eligibility, was the participant in a physical or psychological state which precludes thoughtful consideration of the risks and benefits of participation? ☐1 Yes ☐0 No N:(1,0)
8. Did the participant meet all eligibility criteria? ☐1 Yes ☐0 No N:(1,0)

Note: Patient can be registered after informed consent is signed, date is given, and they have met eligibility criteria.

Penn RADR

Concomitant Medications

PT ID: __ __ __ __ __

PT Initials: __ __ __
(For reference only, not entered)

Line #	Drug Code	Medication Name (Generic or Trade name)	Dose	Frequency	Unit	Route	Start Date	Stop Date
	From Medication Reference Tool			1 = everyday 2 = 2X/day 3 = 3X/day 4 = 4X/day 5 = PRN 98 = Other	1 = puffs 2 = mg 3 = mcg 4 = tablets 5 = ml/cc 6 = tsp 7 = tbsp 8 = oz 9 = drops 10 = spray 11 = units 12 = liters 98 = Other	1 = Inhalant 2 = Oral 3 = IV 4 = IM 5 = SC 6 = Topical 7 = Rectal 8 = Nasal 9 = Transdermal 10 = Sublingual 98 = Other	Check box if continued from an earlier Visit mm/dd/yyyy	Check box if continued or enter Stop Date mm/dd/yyyy
N3	N5	① This field populated w/ name for Drug Code listed in Medication Reference Tool.	N10(8,2)	N2(1-5,98)	N2(1-12,98)	N2(1-10,98)	__/__/ DT __ ☐ N1(1)	__/__/ DT __ ☐ N1(1)
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐
							__/__/____ ☐	__/__/____ ☐

Notes/Comments: N.E.

Penn RADR

Enrollment Visit Patient Information

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

1. Date of Birth _ _/_ _/_ DT _ _ (mm dd yyyy)
2. Sex ❑1 Male ❑2 Female N:(1,2)
3. Ethnicity: Which of the following best describes you? ❑1 Hispanic or Latino ❑2 Not Hispanic or Latino N:(1,2)
4. Race: Which of the following best describes you?
   a. American Indian/Alaskan Native ❑1 Yes ❑0 No
   b. Asian ❑1 Yes ❑0 No
   c. Black/African-American ❑1 Yes ❑0 No
   d. Native Hawaiian/Pacific Islander ❑1 Yes ❑0 No
   e. White ❑1 Yes ❑0 No

   N:(1,0)
5. What zip code do you currently live in? _ _ _ NS _ _
   5a. How many years have you lived in this zip code? _NZ_ years
6. What zip code did you live in prior to your current zip code? _ _ _ NS _ _
   6a. How many years did you live in that zip code? _NZ_ years
7. Has a health care provider ever told you that you have any of the following?

   N:(1,0)

   a. High blood pressure/hypertension ❑1 Yes ❑0 No
   b. Angina or coronary artery disease (narrowed or blocked heart arteries) ❑1 Yes ❑0 No
   c. Heart attack ❑1 Yes ❑0 No
   d. Nasal polyps ❑1 Yes ❑0 No
   e. Chronic sinusitis ❑1 Yes ❑0 No
   f. Allergic rhinitis ❑1 Yes ❑0 No
   g. Atopic dermatitis ❑1 Yes ❑0 No
   h. Eczema ❑1 Yes ❑0 No
   i. Sleep apnea (also called obstructive sleep apnea) ❑1 Yes ❑0 No
   j. "Reflux" or heartburn (also called GERD or gastroesophageal reflux disease) ❑1 Yes ❑0 No
   k. Cancer of the lung ❑1 Yes ❑0 No
   l. Cancer other than lung (breast, colon, ovarian, cervical, etc.) ❑1 Yes ❑0 No
   m. A chronic inflammatory disease (such as sarcoid, lupus, rheumatoid arthritis, Crohn's disease, or ulcerative colitis) ❑1 Yes ❑0 No
   n. Diabetes (high blood sugar) ❑1 Yes ❑0 No
      7q1. If you have diabetes, do you use insulin? ❑1 Yes ❑0 No

8. Which of the following best describes how often you cough? N: (0-4)
   - ❑0 Never (skip to #10)
   - ❑1 Only during a cold or infection
   - ❑2 Some days, even when I don't have a cold or infection
   - ❑3 Most days
   - ❑4 Every day

9. How much mucus do you cough up? N: (0-3)
   - ❑0 None. It's a dry cough
   - ❑1 Less than a tablespoon per day
   - ❑2 Between a tablespoon and half a cup per day
   - ❑3 More than half a cup per day

Questions 10 and 11 ask about how your breathing symptoms have been in the past week

10. During the past week, how often did you have breathing symptoms during the daytime?
    - ❑0 Not at all
    - ❑1 2 days or less
    - ❑2 3 to 6 days
    - ❑3 Everyday

    N: (0-3)

11. During the past week, about how many times each day did you use fast acting or quick relief medication ("rescue medicine") from an inhaler?
    - ❑0 Not at all
    - ❑1 Less than once a day
    - ❑2 1 to 2 times a day
    - ❑3 3 times a day
    - ❑4 4 to 6 times a day
    - ❑5 More than 6 times a day

    N: (0-5)

Questions 12 and 13 ask about how your breathing symptoms have been in the past 4 weeks.

12. During the past 4 weeks, how often did your lung disease wake you up during the night?
    - ❑0 Never
    - ❑1 2 nights or less
    - ❑2 3 to 4 nights
    - ❑3 5 to 10 nights
    - ❑4 More than 10 nights

    N: (0-4)

13. During the past 4 weeks, how often did you get out of breath?
    - ❑0 Never
    - ❑1 Sometimes
    - ❑2 Usually
    - ❑3 Always

N: (0-3)

Questions 14 and 15 ask about hospital visits in the <u>past 6 months.</u>

14. In the past 6 months, how many times have you had to go to the emergency room <u>because of your breathing</u>?
    - ❑0 None
    - ❑1 1 to 2 times
    - ❑2 3 to 4 times
    - ❑3 More than 4 times

N: (0-3)

15. In the past 6 months, how many times have you had to stay at least one night in the hospital <u>because of your breathing</u>?
    - ❑0 None
    - ❑1 Once
    - ❑2 Twice
    - ❑3 Three times
    - ❑4 Four times
    - ❑5 More than four times

N: (0-5)

16. Have you ever been intubated (where the doctors had to put a tube down your throat and a machine had to breathe for you)?
    ❑1 Yes ❑0 No

N: (1,0)

17. Have you ever been diagnosed with eczema (an itchy rash that comes and goes for at least 6 months and typically involves the folds of the elbows, behind the knees, and/or under the buttocks)?
    ❑1 Yes ❑0 No

N: (1,0)

18. Have you ever had a problem with sneezing, or a runny, or blocked nose when you did not have a cold or the flu?
    ❑1 Yes ❑0 No

N: (1,0)

19. <u>In the past 12 months</u>, has this nose problem been accompanied by itchy-watery eyes?
    ❑1 Yes ❑0 No

N: (1,0)

Penn RADR

Enrollment Visit Patient Information

PT ID: _ _ _ _ _ _ PT initials: _ _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

20. Does anyone in your family have any of the following diseases?

Disease	Present	If yes, Who has it					
	N1(1,0)	Mom N1(1,0)	Dad N1(1,0)	Brother or Sister N1(1,0)	Child N1(1,0)	Grand-parent N1(1,0)	N1(1,0) other
Asthma	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N (Please specify below) NE
Emphysema or COPD	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N	☐1Y ☐0N (Please specify below) NE

21. During the past year, how many times have you needed to start (or increase your dose of) prednisone because of your breathing? N1(0-3)

- ☐0 None
- ☐1 1 to 2 times during the past year
- ☐2 3 to 4 times during the past year
- ☐3 More than 4 times during the past year

22. Do you use oxygen at home? ☐1 Yes ☐0 No (skip to #23) N1(1,0)

If ***YES***, when do you use it?

a. At rest	☐1 Yes ☐0 No	N1(1,0)
b. During activity or exercise	☐1 Yes ☐0 No	
c. During sleep	☐1 Yes ☐0 No	

23. Did you ever smoke cigarettes?

- ☐0 Never ***(Please continue to question 24)*** N1(0-2)
- ☐1 Yes, but quit
- ☐2 Yes, still smoking

If the answer of question 23 is "1-Yes, but quit", please complete questions 23a, 23b, and 23c.

23a. How many packs a day, on average? N4(2,2) packs

23b. At what age did you start smoking cigarettes? N2 years old

23c. When was your last cigarette? _ _/_ _/_ DT _
mm dd yyyy

If the answer of question 23 is "2-Yes, still smoking", please complete questions 23d, and 23e.

23d. How many packs a day, on average? N4(2,2) packs

23e. For how many years in all? N2 years

24. Did you ever smoke cigars?

❑0 Never ***(Please continue to question 25)*** N: (0-2)

❑1 Yes, but quit

❑2 Yes, still smoking

If the answer of question 24 is "1-Yes, but quit", please complete questions 24a, 24b, and 24c

24a. How many cigars a day, on average? N4(2,2) cigars

24b. At what age did you start smoking cigars? NZ years old

24c. When was your last cigar? __/__/DT
mm dd yyyy

If the answer of question 24 is "2-Yes, still smoking", please complete questions 24d, and 24e.

24d. How many cigars a day, on average? N4(2,2) cigars

24e. At what age did you start smoking cigars? NZ years old

25. Did you ever smoke a pipe?

❑0 Never N: (0-2)

❑1 Yes, but quit

❑2 Yes, still smoking

If the answer of question 25 is "1-Yes, but quit", please complete questions 25a, 25b, and 25c

25a. How many ounces a day, on average? N4(2,2) ounces

25b. At what age did you start smoking a pipe? NZ years old

25c. When was your last pipe? __/__/DT
mm dd yyyy

If the answer of question 25 is "2-Yes, still smoking", please complete questions 25d, and 25e.

25d. How many ounces a day, on average? N4(2,2) ounces

25e. At what age did you start smoking a pipe? NZ years old

26. When you were a child (up to and including 18 years old), did anyone in your household regularly smoke cigarettes indoors? Include parents, other relatives, roommates, etc.

❑1 Yes ❑0 No N: (1,0)

26a. If yes, how many hours per day were you exposed? N4(2,2) hours

26b. If yes, how many years were you exposed to this smoke? N4(2,2) years

27. In your adult years (over 18 years old), have you ever been exposed to other people's cigarette smoke on a regular basis? Include spouse, children, other relatives, co-workers, roommates, etc.

❑1 Yes ❑0 No N: (1,0)

28. Before your current diagnosis, did you ever drink alcohol regularly (at least one drink per week for one year's time)?

❑1 Yes ❑0 No ***(Please continue to question 29)***

28a. If yes, how old were you when you started drinking regularly? (once a week for one year's time) NA years old

28b. If yes, do you still drink alcohol at least once a week?

❑1 Yes ❑0 No NA (1,0)

28c. If you do not still drink alcohol at least once a week, how many years ago did you stop drinking alcohol altogether or start drinking it only occasionally?

NA years ago

29. What job have you worked at the longest? Please describe what you did on a daily basis:

CHR 250

30. What job have you worked at the second longest? Please describe what you did on a daily basis:

CHR 250

Penn RADR

Enrollment Visit Patient Information

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

Have you ever been exposed to any of the following? (**exposure is defined as at least 5 hours per week for at least 1 year**)

31. Wood dust ❑1 Yes ❑0 No N1 (1,0)

31a. If Yes, what is the total number of years you were exposed to wood dust?
N4(2,2) _____ years

32. Diesel engine exhaust ❑1 Yes ❑0 No N1 (1,0)

32a. If Yes, what is the total number of years you were exposed to diesel engine exhaust?
N4(2,2) _____ years

33. Asbestos ❑1 Yes ❑0 No N1 (1,0)

33a. If Yes, what is the total number of years you were exposed to asbestos?
N4(2,2) _____ years

34. Coal dust ❑1 Yes ❑0 No N1 (1,0)

34a. If Yes, what is the total number of years you were exposed to coal dust?
N4(2,2) _____ years

35. Is there any other substance you remember being exposed to?

❑1 Yes ❑0 No N1 (1,0)

35a. If Yes, please describe the substance and your exposure:
CHR 250

35b. If Yes, what is the total number of years you were exposed to this substance?
N4(2,2) _____ years

Penn RADR

Follow-up Patient Information

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

1. Which of the following best describes how often you cough? N1 (0-4)
   - ❑0 Never (skip to #3)
   - ❑1 Only during a cold or infection
   - ❑2 Some days, even when I don't have a cold or infection
   - ❑3 Most days
   - ❑4 Every day

2. How much mucus do you cough up? N1 (0-3)
   - ❑0 None. It's a dry cough
   - ❑1 Less than a tablespoon per day
   - ❑2 Between a tablespoon and half a cup per day
   - ❑3 More than half a cup per day

Questions 3 and 4 ask about how your breathing symptoms have been in the past week

3. During the past week, how often did you have breathing symptoms during the daytime?
   - ❑0 Not at all
   - ❑1 2 days or less
   - ❑2 3 to 6 days
   - ❑3 Everyday

   N1 (0-3)

4. During the past week, about how many times each day did you use fast acting or quick relief medication ("rescue medicine") from an inhaler?
   - ❑0 Not at all
   - ❑1 Less than once a day
   - ❑2 1 to 2 times a day
   - ❑3 3 times a day
   - ❑4 4 to 6 times a day
   - ❑5 More than 6 times a day

   N1 (0-5)

Questions 5 and 6 ask about how your breathing symptoms have been in the past 4 weeks.

5. During the past 4 weeks, how often did your lung disease wake you up during the night?
   - ❑0 Never
   - ❑1 2 nights or less
   - ❑2 3 to 4 nights
   - ❑3 5 to 10 nights
   - ❑4 More than 10 nights

   N1 (0-4)

6. During the past 4 weeks, how often did you get out of breath?
   - ❑0 Never
   - ❑1 Sometimes
   - ❑2 Usually
   - ❑3 Always

   N: (0-3)

Questions 7 through 12 ask about the time period since your last registry visit to this clinic, which was on _ _/_ _/_ _ NE _ _.

7. Since your last registry visit to this clinic, how many times have you had to go to the emergency room because of your breathing?
   - ❑0 None
   - ❑1 1 to 2 times
   - ❑2 3 to 4 times
   - ❑3 More than 4 times

   N: (0-3)

8. Since your last registry visit to this clinic, how many times have you had to stay at least one night in the hospital because of your breathing?
   - ❑0 None
   - ❑1 Once
   - ❑2 Twice
   - ❑3 Three times
   - ❑4 Four times
   - ❑5 More than four times

   N: (0-5)

9. Since your last registry visit to this clinic, have you been intubated, where the doctors had to put a tube down your throat and a machine had to breathe for you?
   - ❑1 Yes ❑0 No

   N: (1,0)

10. Since your last registry visit to this clinic, have you needed to start (or increase your dose of) prednisone because of your breathing?
    - ❑1 Yes ❑0 No

    N: (1,0)

11. Which of the following best describes how often you smoked since your last registry visit to this clinic? (choose one)
    - ❑1 Every day
    - ❑2 Most days
    - ❑3 Some days
    - ❑0 Not at all (skip to #13)

    N: (0-3)

12. Since your last registry visit to this clinic, how much per day did you smoke, on average? (*Please choose only one of the options for answering below)

a. NA(z,z) cigarettes per day

Or

b. NA(z,z) packs per day

13. Do you use oxygen at home? ❑1 Yes ❑0 No (STOP) NI (1,0)

If ***YES***, when do you use it?

a. At rest	❑1 Yes ❑0 No	NI (1,0)
b. During activity or exercise	❑1 Yes ❑0 No	↓
c. During sleep	❑1 Yes ❑0 No	

Penn RADR

LAB RESULTS

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

1. Lab date _ _/_ _/_ DT _ _ (m m / dd / y y)

Hematology Results:

2. Were Hematology Tests completed? ☐1 Yes ☐0 No NI (1,0)

Test Performed	Results	
White Blood Cell	NE (2,1) _ _ . _ (thousand/uL)	☐99 Not Done
Lymphocytes	NE (3,1) _ _ . _ %	☐99 Not Done
Granulocytes/Neutrophils	NE (3,1) _ _ . _ %	☐99 Not Done
Bands	NE (3,1) _ _ . _ %	☐99 Not Done
Monocytes/Macrophages	NE (3,1) _ _ . _ %	☐99 Not Done
Eosinophils	NE (3,1) _ _ . _ %	☐99 Not Done
Basophils	NE (3,1) _ _ . _ %	☐99 Not Done
Hemoglobin	NE (2,1) _ _ . _ (g/dL)	☐99 Not Done
Hematocrit	NE (2,1) _ _ . _ (%)	☐99 Not Done
Platelet count	NE _ _ _ (thousand/uL)	☐99 Not Done
Prothrombin time (PT)	NE (2,1) _ _ . _	☐99 Not Done
International Normalized Ratio (INR)	NE (1,1) _ . _	☐99 Not Done
Activated partial thromboplastin time (aPTT)	NE (3,1) _ _ . _	☐99 Not Done
Vitamin D*	NE Please disable (IU)	☐99 Not Done

NE (97)

NE Please disable

***Please note:** Vitamin D test results are not to be recorded on this form.*
Please record all Vitamin D test results on the Vitamin D Results Log.

Penn RADR

LAB RESULTS

PT ID: _ _ _ _ _ _ PT initials: _ _ _ _ Visit #: _ _

Visit Date:_ _/_ _/_ _ _ _ RC ID: _ _ _ Site #:_ _

Chemistry Results:

3. Were Chemistry Tests completed? ☐1 Yes ☐0 No N1 (1,0)

Test Performed	Results	
Bicarbonate (HCO3 or CO2)	N2 (mmol/L)	☐99 Not Done
Blood urea nitrogen (BUN)	N2 (mg/dL)	☐99 Not Done
Creatinine	N3 (1,2) . (mg/dL)	☐99 Not Done
Glucose	N3 (mg/dL)	☐99 Not Done
Sodium	N3 (mmol/L)	☐99 Not Done
Potassium	N2 (1,1) . (mmol/L)	☐99 Not Done

N2 (99)

Other Lab Results:

4. Were Other Lab Tests completed? ☐1 Yes ☐0 No N1 (1,0)

Test Performed	Results	
Quantitative Immunoglobulin E (IgE)	N3	☐99 Not Done
Alpha-1 Antitrypsin Level	N3 (mg/dL)	☐99 Not Done

N2 (99)

VITAMIN D RESULTS LOG

Penn RADR

PT ID: __ __ __ __ __

PT initials: __ __ __
(For reference only, not entered)

Line Number	Date Vitamin D Test Performed	Vitamin D Test Result
N3	__ __/__ __/__ __ __ __ mm dd yyyy DT ≠ SYSDT.	__ __ N6 __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)
__ __ __	__ __/__ __/__ __ __ __ mm dd yyyy	__ __ __ __ __ __ (IU)

Penn RADR

PFT RESULTS

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ _ Site #: _ _

1. Was PFT ordered? ☐1 Yes ☐0 No N1 (1,0)
2. PFT date _ _/_ _/_DT_ _ (mm / dd / yyyy)
3. PFT Location N1 (1-3)
   - ☐1 HUP
   - ☐2 Presbyterian
   - ☐3 Outside Hospital
4. PFT Results:

Test performed	Pre-Bronchodilator		Post-Bronchodilator	
	Absolute	*% Predicted*	*Absolute*	*% Predicted*
a. FVC	N3(1,2:1.00-4.00) _ . _ _	N3(10-120) _ _ _ %	N3(1,2:1.00-4.00) _ . _ _	N3(10-120) _ _ _ %
b. FEV1	N3(1,2:0.40-3.50) _ . _ _	N3(10-120) _ _ _ %	N3(1,2:0.40-3.50) _ . _ _	N3(10-120) _ _ _ %
c. FEV1/FVC	N3(10-100) _ _ _	N3(20-100) _ _ _ %	N3(10-100) _ _ _	N3(20-100) _ _ _ %
d. PEFR (FEF Max)	N3(2,1:0.50-6.0) _ . _ _	N3(10-120) _ _ _ %	N3(2,1:0.50-6.00) _ . _ _	N3(10-120) _ _ _ %
e. TLC	N4(2,2:4.00-10.00) _ _ . _ _	N3(80-250) _ _ _ %	☐99 Not Done N1(99)	
f. RV	N3(1,2:1.50-6.00) _ . _ _	N3(80-350) _ _ _ %	☐99 Not Done	
g. DLCO	N4(2,2:5.00-40.00) _ _ . _ _	N3(5-100) _ _ _ %	☐99 Not Done	

Testing Checklist

Penn RADR

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

1. Height N4(3,1) _ _ _._ inches
   ❑99 Not done N2(99)

2. Weight N4(3,1) _ _ _._ pounds
   ❑99 Not done N2(99)

Was test performed	Test type	Testing completed
3. Pulmonary Function Tests:		
N1(1,0) ❑1 Yes ❑0 No	Spirometry N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Lung Volumes N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Diffusing capacity N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Methacholine Challenge N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Other: Specify: CHR 2D N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
4. Laboratory Tests:		
N1(1,0) ❑1 Yes ❑0 No	Chemistries (Panel 7, etc.) N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Hematology (CBC, etc.) N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Quantitative IgE N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Arterial blood gases N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Other: Specify: CHR 2D N1(1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered

Penn RADR

Testing Checklist

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

Was test performed	Test type	Testing completed
5. Radiology:		
NI (1,0) ❑1 Yes ❑0 No	CXR (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Chest CT (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	V/Q Scan (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Other: Specify: CHR 20 (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
6. Exercise Testing:		
NI (1,0) ❑1 Yes ❑0 No	6 Minute Walk test (6MWT) (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Exercise Desaturation test (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Cardiopulmonary exercise test (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Other: Specify: CHR 20 (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
7. Cardiac Testing:		
NI (1,0) ❑1 Yes ❑0 No	Echocardiogram (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Cardiac catheterization (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Other: Specify: CHR 20 (NI (1-3))	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered

Penn RADR

Testing Checklist

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _

Was test performed	Test type	Testing completed
8. Additional Tests		
NI (1,2) ❑1 Yes ❑0 No	RAST testing NI (1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Skin allergen testing NI (1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered
❑1 Yes ❑0 No	Other: Specify: CHR 20 NI (1-3)	❑1 Today ❑2 Completed on _ _/_ _/_ _ DT _ _ ❑3 Scheduled/Ordered

9. Is a follow-up visit scheduled? ❑1 Yes ❑0 No NI (1,2)

   a. If yes, tentative date of next visit scheduled? _ _/_ _/_ _ DT _ _

Penn RADR

Participant Reinstatement

PT ID: _ _ _ _ _ _ PT initials: _ _ _ Visit #: _ _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ Site #: _ _ _

This form should be completed *ONLY* if the participant was previously withdrawn from the RADR study and is now being reinstated.

1. Please indicate the primary reason for reinstatement: NZ (1-5, 98)
   - ☐ 1 Previously not interested but returned
   - ☐ 2 Now willing to follow the protocol
   - ☐ 3 Previously lost to follow-up but now returned
   - ☐ 4 Personal constraints have changed
   - ☐ 5 Medical condition unrelated to asthma has improved
   - ☐ 98 Other Please specify: CHR 20
2. Was the RC informed of the reinstatement? ☐ 1 Yes ☐ 0 No N1 (1,0)
3. Did the patient sign a new Consent Form? ☐ 1 Yes ☐ 0 No
4. Was the patient re-screened? ☐ 1 Yes ☐ 0 No
5. Was the Patient Contact Information re-administered? ☐ 1 Yes ☐ 0 No

Comments: _____

_____

_____

_____

_____

_____

Penn RADR

Participant Withdrawal

PT ID: _____ PT initials: ___ Visit #: ___

Visit Date: __/__/____ RC ID: ___ Site #: ___

1. Please indicate the primary reason for withdrawal? N2 (1-5, 98)

   - ☐1 No longer interested in participating
   - ☐2 No longer willing to follow the protocol
   - ☐3 Lost to follow-up
   - ☐4 Patient deceased
   - ☐5 Access to clinic is too difficult
   - ☐6 Unable to make visits during clinic hours
   - ☐7 Unable to continue due to personal restraints
   - ☐8 Unable to continue due to medical condition unrelated to Asthma
   - ☐98 Other Specify: cHR 20

2. Did the participant request their data collected for the Patient database to be removed? ☐1 Yes ☐0 No N1 (1,0)

   a. If yes, signature of DCC personnel NE Date: mm/dd/yyyy DT

3. Did the participant request the Specimen Repository (blood sample collection) be disposed? ☐1 Yes ☐0 No N1 (1,0)

4. Did the participant request the blood sample for genetic testing be disposed? ☐1 Yes ☐0 No N1 (1,0)

   a. If "yes" to Q #3 or 4, signature of personnel NE Date: mm/dd/yyyy DT

Comments: _____

Penn RADR

Specimen Collection and Transfer

PT ID: _ _ _ _ _ _ _ PT initials: _ _ _ _ Visit #: _ _

Visit Date: _ _/_ _/_ _ _ _ RC ID: _ _ _ _ Site #: _ _

1. Did the participant agree to genetic testing? ☐1 Yes ☐0 No N1 (1,0)

2. Collection: Date: _ _/_ _/_ _ DT _ _ (mm/dd/yyyy) Time: N2(00-23) N2(00-59) _ _ : _ _ (military time)

3. Specimen collection status:

Spec. #	Specimen Type	Was the specimen collected? (Check one below)	Reason specimen not collected (Choose one response below for each specimen not collected) 1. Poor venous access 2. Participant refused 3. Inadvertently destroyed 4. Over-sight 98. Other	Number of Cryotubes Collected
1.	Red Top Tube (Serum)	N1(1,0) ☐1 Yes ☐0 No	N2(1-4,98) _ _	N1(0-8) _ of 8
2.	Purple Top Tube (RCF)	☐1 Yes ☐0 No	_ _	N1(0-8) _ of 8
3.	Purple Top Tube (Whole Blood)	☐1 Yes ☐0 No	_ _	N1(0-3) _ of 3
4.	Purple Top Tube (Plasma)	☐1 Yes ☐0 No	_ _	N2(0-12) _ of 12
5.	Purple Top Tube (Buffy Coat)	☐1 Yes ☐0 No	_ _	N2(0-2) _ of 2
6.	Purple Top Tube (Packed RBC)	☐1 Yes ☐0 No	_ _	N1(0-5) _ of 5
7.	Purple Top Tube (CAG Blood)	☐1 Yes ☐0 No	_ _	N1(0,1) _ of 1
8.	Urine	☐1 Yes ☐0 No	_ _	N1(0,1) _ of 1

Contact information of the Clinical Center personnel responsible for specimen packing and shipment:

Clinical Center personnel:

☐1 Presbyterian ☐2 HUP Pulmonary Clinic ☐3 HUP Transplant Clinic ☐4 ABI } Not entered

Name: _____

Phone: (_ _ _) _ _ _-_ _ _ _ Fax: (_ _ _) _ _ _-_ _ _ _

Date of specimen shipment: _ _/_ _/_ _ _ _ (mm/dd/yyyy)